Contracting Models and Provider Competition in Europe

WHO Book on European Health Care Reforms

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Introduction

Health care reforms which are underway at the moment in many European countries are focused on the contracting type of relationships between payers and providers of health care. Contracting model is increasingly seen as an instrument to implement health policy objectives. It is considered a new coordinating mechanism which offers a promising alternative to the traditional command—and—control type of coordination in health care management.

Related to that, is the search for market or quasi—market oriented mechanisms of resource allocation. An essential element of the new approach is a move from hierarchical or highly integrated forms of service delivery and finance towards the models based upon purchaser—provider separation. Contracting is seen as a tool for this separation. Through contracting mechanisms third—party payers and providers are getting bound by explicitly specified commitments and also gain economic motivation to follow these commitments.

Contracting is not entirely a new mechanism. In many countries counteracting between third—party payers and suppliers of health services has developed as a common coordinating mechanism over the last few decades. In the Netherlands and Germany, for instance, complex institutional structures have been created in which representative organizations of health insureres and physicians negotiate contracts on payment schemes for physicians services to patients. However, currently the nature and the role of contracting is changing. Much stronger emphasis is placed on the role of contracting as a planning tool and also as the way to encourage providers competition. This makes contracting a part of a more generic process of reforming health care systems.

This paper explores the processes of contracting and health providers competition with the view of giving specific recommendations for health policy. The first section addresses the conceptional issues of contracting, such as the reasons for development of contracting in the health sector, potential implications of contracting for public health policy, alternative approaches to contracting in competitive and non—competitive environment. The option of typology of contracting relationships is proposed for further analyses.

The second section outlines the trends in contracting across countries with different health systems both as currently practiced, as well as in relation to what countries in the Region are trying to achieve through health care reform. The revealed issues of contracting are also discussed.

In the third section contracting in competitive environment is explored. A few issues regarding market approaches are discussed: the feasibility of providers competition in countries with highly integrated systems, the evidence of the providers competition in some countries of the European region, the role of health purchasers in encouraging competitive contracting, the algorithm and pre—conditions of competitive contracting. It is argued that competitive environment reinforces potential strengths of contracting. There is no contradiction between using contracting as planning tool and as the way to select the most efficient providers.

The paper is complete with the conclusions and recommendations to health policy makers regarding the role of contracting and providers competition.

1. Conceptional issues of contracting in health care

1.1. Why contracting?

A critical issue in the literature points to the role of contracting in health care management. Discussions on the value of contracting are still mainly theoretical in most of the countries which have started the reforms. However, there are some apparent arguments to its great potential as a promising coordinating mechanism in health care sector. Moreover. the first evidence across countries gives some proof to these arguments. Following are at least five ***reasons*** for the move from highly integrated and hierarchial health models to contractual relationships.

1.To encourage decentralization of management. This reason for the interest in contracting has been brought up by Harrison in the study of contracting in the NHS in Britain. He points out that contracting gives great potential to delegate more responsibility down the line of management so that providers and lower−level managers would be given more power in decision making on deployment of resources for meeting the population needs (Harrison, 1993). In more specific terms, two major mechanisms can be used for decentralization of management through contracting: i) clear specification of commitments of contracting parties in terms of what services are to be provided and paid, and on which terms, ii) risk arrangements between purchasers and providers.

As to the first mechanism, it makes the providers' commitments actual rather than declarative. They are bound by contractual provisions in terms of the outcomes rather than inputs for performance. These commitments are linked to the actual financial resources available, which is particularly important for the countries of Central and Eastern Europe (CCEE/NIS) where the health sector is greatly underfunded because of the traditional allocation of funds to this sector by a "residual" method. After specification of contractual arrangements it does not make sense for the payer to operate providers directly. They gain some level of the autonomy to decide (within effective rules and regulations) on the size, skill mix and pay of the staff, bed capacity, types of equipment purchased, and other characteristics of the work. In other words, the clear specification of commitments of both sides makes decentralization of management the imperative of the state policy rather than the subjective choice of decision makers.

The role of health authority or the owner of the assets is limited to specifications on the demand side − population needs assessment, analyses of resources available, developing requirements to the parameters of care, and negotiating them with potential providers. They are not obliged to contract with local providers, and can select providers with high performance.

Contracts constitute the essential link between purchasers and providers by special provisions on risk sharing arrangements. The traditional responsibility of third−party payer on covering unpredicted expenditures gives way to contractual sharing of risks between purchasers and providers. This makes the

latter risk bears and thereby encourage them to look for the ways to increase efficiency. The types of risk sharing arrangements range from simplified contractual provisions in cost and volume contracts with hospitals (in the NHS reform in the UK) to the GP fundholding schemes (in the UK and some regions of Sweden and Russia) and also to more sophisticated risk sharing arrangements within HMO−type settings in the USA. Their common feature is that providers become more exposed to the uncertainties of the health world, i.e. to some degree responsible for unplanned events on either supply or demand side.

3. To exert more control over the performance of providers. There is an universal urge to ensure efficient performance of providers by introducing new mechanisms of control over the performance of providers. At first sight, this intention is conflicting with the above mentioned decentralization of management. However, the mechanisms of contracting allow to resolve this conflict by changing the nature of relationships within highly integrated systems.

First, clear−cut contractual provisions can overcome blurred responsibilities and accountability of the parties and thereby give payers strong levers to control the actual implementation of the providers' commitments. Hospitals and physicians are financially responsible for the provision of the specified volume, quality and mix of services at negotiated or regulated price.

Second, contracting is based on monitoring and evaluation procedures with a special emphasis on the performance indicators. For example, the current contracting in NHS in the UK offers the explicit format which formalizes the process of monitoring and evaluation by the specification of targets and performance indicators (Contracts for Health Services, 1990). This enables purchasers to substantiate any claims for better performance of providers and also to settle the disputes. The major limitation for the implementation of this kind of control is the availability of data.

3. To improve planning of health care development. In recent years planning systems have encountered a number of problems which have substantially reduced their potential in meeting health care objectives (Saltman and van Otter, 1992). The new approaches are developed, of which contracting is one of the most important. The rationale for using contracting as a planning tool is that it provides direct link between planning and resource allocation, as providers become economically motivated to follow the strategy of planning embodied in contractual arrangements. Planning agency is taking the role of contractual party in contrast to the Soviet−style commands to implement the plan.

Contracting can be regarded as an alternative way to do some of the same things which traditionally have been accomplished by planning. Even further, we argue that the incorporation of contracting into planning can significantly facilitate the planning process by breaking some of the deadlocks that the practice of planning has encountered.

Plans can be more effectively translated into action; purchasers engaging in health needs assessment and establishment of priorities are to pay selected providers to deliver those services which will best meet the needs of resident populations. For example, the plan to deploy the interregional diagnostic center

may take the contractual form, whereby the regions involved in the project are committed to sharing resources and expenses for running the new facility.

Another innovation of contracting model of planning is that it makes users of new facilities to: i) tighten requirements to the "quality" of plans developed by planning agencies, ii) rationalize the use of new facilities according to the actual needs, because they are supposed to take the burden of covering costs of new facilities.

Moreover, contracting can encourage the development of information systems. This can be seen as an additional benefit of contracting. Purchasers interested in the practice of good contracting would pursue information systems in health status, health needs, health services outcomes, cost of health services, and performance of providers, without which informed contracts cannot be written.

4. To improve management of care. One of the major objectives of contracting is to influence the structure of health care provision by offering the mechanisms of committing purchasers and providers to changes in the pattern of care provision, in particular, to a shift from inpatient to outpatient care, and also to more cost−effective medical interventions. This strategy is of particular importance for the CCEE/NIS. The decades of bureaucratic control of health systems have caused substantial distortions of health care provision structure, unknown to Western countries (for example, inpatient care expenditures in Russia amount to around 70% of health expenditures against the OECD average 44% for hospitals and 55% for hospitals plus long term care; share of primary care physicians in total number of physicians is only around 25%, while in Canada it is close to 70%; the rate of hospital admissions is 23 per 100 against the OECD average 16,2; referral rate to specialists is reported as more than 30%, while in the UK is 8,6%, the Netherlands −7,9, see Sheiman, 1995). To a lesser degree this is also the issue for many Western countries, particularly the USA.

Contracting is increasingly seen as the instrument of implementation of the strategy for overcoming health care structure distortions. The new contracting instruments are designed to increase allocative efficiency of health care provision by setting up vertical network of hospital−physician groups and their funding on the capitation basis with a number of contracts within the group.

The value of contracting for the improvement of management is further extended to increasing potential of health authorities as actual management agencies. Administration gives way to management of health care. In the role of purchasers they are free to represent the interests of the citizenry they serve, as they are no longer responsible for the provider side of health services delivery. Payers under contracting can therefore engage in assessment of health needs for their resident populations. Based on this information, they can establish priorities for allocating resources among alternative uses. The traditional epidemiological approach to setting priorities, based on a measure of the population's ill health, can be complemented by the incorporation of cost−effectiveness considerations. Purchasers can appraise options for delivery of required services, and engage in purchasing with providers in order to best secure delivery of these services. By representing the consumer of health services, purchasers gain the opportunity to secure the most appropriate pattern and balance of curative, health promotion, and disease prevention services for their populations.

5. To encourage the local choice of health care. The move to contracting has placed greater emphasis on competitive mechanisms. This can be implemented in the forms of individual and collective choice exercised by the purchaser on behalf of the subscribers. The actual choice is often impeded by a number of institutional constraints (see section 3.1.). However, there are mechanisms to introduce the elements of the local choice of providers by purchasers through selective contracts. For example, GPs may select specialists and hospitals if they are financially interested in this selection.

Similarly, contracting may encourage competition of purchasers. For example, insurance companies would increase their market share by offering health insurance policies with various options increasing the number of medical benefits for subscribers. This makes the role of contracting between health insurers and the public more prominent.

By separating the functions of purchasing from functions of provision of care, it is also intended to overcome the traditional dominance of providers over consumers and payers. Contracting makes purchasers the champions of the people who are expected to drive the system. Contracting also changes the balance of power between payers and providers. The administrative dominance gives way to the discussion, negotiation, risk sharing and exchange of information on the needs and providers performance.

The above mentioned arguments for contracting allow to summarize the major ***distinctions*** between contractual and non−contractual relationships.

- Purchasing rather than direct allocation of resources to health care providers.

- Payment for the explicit specification of volume, price and quality of services rather than for deployment of resources.

- Monitoring and evaluation of contractual relationships rather than command and control system.

1.2. Issues in contracting from a public health point of view

Contracting and equity. Contracting offers opportunities for supporting equity through the assessment of needs, which can take explicit account of vulnerable and disadvantaged groups, and underserved communities. However, contracting has also raised concerns that there may be dangers which can undermine equity.[1]

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[1] *For example, it has been argued that services which are less profitable, as opposed to less efficient, may be underemphasized or phased out. Rapid throughput services for acute conditions could increase in importance relative to services for the chronically ill. Providers could try to avoid disadvantaged communities, if by serving them they make losses. Or, services in deprived areas could be of a lower quality in order to keep costs within a budget (as disadvantaged groups may be more costly to treat than the average) (Whitehead).*

Possible benefits from contracting stem from the role of purchasers as representatives of the interests of their populations, who will therefore allocate resources and purchase services in accordance with the needs of their citizenry. Assessments of needs can take into consideration the socio−economic distribution of poor health, of risk factors, and determinants of health. They can therefore identify inequalities in health and provision, which can be ameliorated through appropriate resource allocation and service specification. In addition, the inclusion into contracts of quality specifications can be used to raise standards of care for underprivileged areas and communities.

Contracting and community participation. Contracting can serve public health objectives in that it can become the medium through which health needs of populations are linked to actual policies. Purchasers take on the responsibility of deciding what health services are to be produced, and for whom, and thus secure the allocation of resources for better health.

Community participation in contracting can generate a democratization process in health services, increase the accountability of governments and the medical profession, and make health policy more relevant to the needs and priorities of society.

The process of contracting can be divided into three stages: the pre−contracting stage, the actual contract or written agreement stage, and the post−contracting stage. Community participation can take place in all three of these stages.

In the pre−contracting period, participation of diverse groups of a community should be an important element in the process of health needs assessment, as these groups can be a major input in determining local needs and wants. Consumers can assist in the process of setting priorities and in decision−making which could involve rationing and shifting patterns of services provision. An input into making difficult decisions and choices (such as rationing) would make the resulting outcomes more relevant to consumer preferences, and hence more politically acceptable. In addition, citizens' groups can participate in the actual contracting, by taking part in purchasing groups. In the post−contracting phase, participation could involve patients' groups with a role in the monitoring and evaluation of the contracting agreements. Through their personal experiences with providers, patients could assist purchasers in monitoring and evaluating the performance of providers.

Contracting and intersectorality. It can hardly be argued that intersectorality is present in contracting as currently practiced, since contracting today focuses mainly on primary, secondary, and tertiary curative care. On the other hand, numerous aspects of curative care are linked with other activities in a community, such as education, labor affairs, and social protection mechanisms, to mention but a few. Contracting could therefore be used as a mechanism to introduce the different interfaces of these activities into health care.

In addition, there are potentials for contracting to be implemented in areas other than health care, i.e. community and environmental health services. These areas are very much interrelated with activities of society in sectors other than health. It is clear that health services would benefit significantly from a cooperation between the relevant sectors. In this context, contracting could be an implementation tool which can help transform intersectorality from an abstract notion into a reality. Contracting clarifies and makes explicit the duties, obligations and rights of concerned parties, thus offering the potential to bring out clearly the responsibilities of the different areas/sectors and their possible linkages.

1.3. Two approaches to contracting.

The conceptional framework of the paper is based on the assumption that two approaches to contracting are possible. First, contracting can be seen as an instrument of health care planning and management in both competitive and non−competitive environments. This approach implies that contracts can be an integral part of the planning process, irrespective of the role market mechanisms play in resource allocation. In other words, contracting is regarded as the formalization of planning and management process with explicit commitments of contracting parties to planning and management objectives and targets.

Under the second approach contracting is seen as a tool of informed selection of providers. This is the type of contracting which is implemented in competitive environment and designed to encourage the local choice by competitive tendering for the package of medical benefits and services. To make contracting competitive certain requirements and procedures must be developed and implemented(see section 3.4).

Contracting between third party payers and providers has the potential to offer certain advantages to the processes of health policy implementation in the absence of any significant competitive pressures on purchasers and providers. Contracts can be incorporated into planning and management process, provided that medical facilities are paid for the precise mix of services specified in the contract. However, this type of contracting can serve only as the first step in changing the performance incentives of providers. The second and major step, in our view, is to make contracting competitive. The well known market failures can not be regarded as insurmountable obstacle to the introduction of market or quasi−market mechanisms (see, for example, Hsiao, 1995). Competition can be seen as a means of promoting productive efficiency by ensuring that inefficient providers are not awarded contracts. But by making contracting more selective its potential to affect quantity, quality and cost of care can be increased.

The two approaches do not contradict each other. The requirements placed by purchasers in the course of competitive tendering may include the provisions designed to improve planning of resources and management of health care structure. Plans are designed and implemented to expand market share of the provider. For instance, contractual arrangements in HMO−type settings in the highly competitive market structure of health care in the USA contain a number of provisions which are very familiar to those who have grown up in a traditional top−down planning system,such as closed panels and limitations on consumer choice. But all those provisions are aimed at improving the market position of

the HMO, that is contracting as a planning and management tool eventually makes purchasers and providers more competitive in terms of the costs and utilization (Sourcebook on HMOs, 1995).

The potential of contracting is largely dependend on the methods of payment to providers under contractual arrangements. Contracts may easily aggravate the weaknesses of the method of payment in use by "legalizing" the structural distortions caused by it. This may be true for both competitive and non-competitive contracts. For example, highly competitive contracts with hospitals and physicians in the USA. which have been based on retrospective methods of payment have failed to contain costs and improve efficiency with unclear evidence of higher quality. Hospitals tend to shift costs to insurers, look for the "niches" with the highest financial return, ignore more cost-effective medical interventions (Higgins, 1991). Therefore, the issue of relative values of contracting in competitive and non-competitive environment may turn out irrelevant unless health policy objectives and targets are set and basic requirements to efficient contracting are met.

1.4. Typology of contracting relationships

Contracts define relationships between many categories of participants in any health care system. The types of contracts vary widely. The proposed typology of contracting relationships is based on the following criteria:

- contracting parties
- legal status of contracts
- the contents of contracting
- comprehensiveness of contracting, that is the level and scope of contractual relationships (bilateral vs. multilateral relationships).

Contractual parties

According to the first criteria, different types of contracts can be signed. In Beverage model the demand side is represented by the governments of all levels, health authorities. The recent innovation in the UK, Sweden, Russia is that primary care providers are acting as purchasers of care as well. On the supply side are the providers of all levels. The subject of the contracts might be not only inpatient or outpatient care, but also public health, programs for specific diseases, community care. In Bismarck model the scope of the contracting by the government is much narrower, as insurers act as the purchasers of care. So the area of contracting here is between insurers and employers or individual subscribers, and also between insurers and providers of care. This might be supplemented by contracts between insurers and the government for provision of subsidies, and also between insurers and central insurance agencies.

In Bismarck model some purchaser-provider relationships sometimes are regulated by collective rather than individual contracting, for example contracts between physician associations and insurers (or their associations). Sometimes collective contracting is also used in countries with a predominant model of individual contracting. In the USA in the recent years a so called 'umbrella contracting" has been used for loose associations of physicians. In this format, the physician authorizes a loose association of peers to negotiate physician

services contracts with purchasers. This contract specifies the general rules of contracting and spares the trouble for individual contractors to negotiate too many provisions (Kongstvedt, 1993). Similar contracting is underway in Russia. The agreement between the regional government, insurance fund and association of health providers serve the basis of individual contracts.

The legal status of contracts

There is a distinction between "hard" and "soft" contracting. Under hard contracting, the contracting parties are relatively autonomous and press their interests actively and strongly. Under soft contracting, contracts have a lower degree of formality, and contracting parties have a closer identity of interests. The relationship between third party payers and providers depends more strongly on cooperation, mutual support, trust, and continuity in relations, as opposed to competition and opportunism (Saltman and von Otter, 1992). Soft contracts are less likely to be legally binding. For example, in the contractual relationships emerging following the reforms of the UK National Health Service, contracts are not legal documents, and the government did not intend that they should be legally enforceable. As such, they could also be described as "service agreements" and "understandings", and would not be defined as "contracts" in the legal sense defined above.

Contracting may therefore be defined as a process of negotiations between at least two parties consisting of third party payer(s) and provider(s), and resulting in a mutual agreement involving specified rights and obligations. This agreement may or may not be legally binding, and it may be a hard or soft variant.

The role of purchasers in contracting differs depending on their legal status of providers. When contracting with independent or autonomous providers (e.g.hospital trusts), health authorities are acting as purchasers with all rights and responsibilities, which apply to the relationships between entities, each of which is voluntarily and deliberately engaging in an exchange. When contracting with state−owned providers, they are acting as "commissioners", that is fulfill the agreed duties in relationships with providers as a representative of the government. In the former case we have purchaser/provider split, in the latter − commissioner/provider split. This is a functional rather than institutional separation of duties.

The distinction between purchasing and commissioning can be related to the distinction noted earlier between hard and soft contracts. Purchaser−provider relationships can be based on either hard or soft contracts. By contract, commissioner−provider relationships are more likely to be less formal, and to be based on trust, continuity, and cooperation, thus involving a soft variant of contracting.

The content of contracts

Three types of contracts are normally used under purchaser (commissioner) − provider split.

(i) Block contracts. These can be likened to a budget for a defined service. The purchaser (or commissioner) agrees to pay a fee in exchange for access to a broadly defined range of services. This type of contract predominates because of deficiencies in information (such as on the cost—effectiveness of treatments, and treatment cost structures). In the simplest block contracts, there is no specification of the number of patients (volume) and cost per patient. Increasingly, however, indicative levels of service as well as more detailed specifications are being written into block contracts. These may include an agreed specification of the number of patients to be treated, or of the services or specialties to be offered by the provider. Block contracts may additionally contain agreements concerning maximum and minimum volume of services to be provided and also assessment/monitoring of quality, though this area remains as yet underdeveloped due to the lack of information on cost effectiveness and health outcomes.

(ii) Cost and volume contracts. These represent a refinement of the block contracts in that payment for specific services is more explicitly related to the services to be offered. For example, they may entail an agreement for the purchaser (or commissioner) to pay a specified amount for a specified number of persons to be treated by one specialty. In a further refinement, the payments may be differentiated in accordance with the service rendered (for example, high, medium, and low cost categories).

(iii) Cost per case contracts. A single cost is set for each item of service. To date, limited use is made of this type of contract as it requires information on the cost of individual treatments at a level of detail and precision which is not currently available. Cost information systems are in the process of being developed and are increasingly being used in connection with efforts toward more effective resource management[2]

All types of contracts in use cover numerous areas, but contracts normally have the minimum list of provisions on:

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[2] *Cost information systems focus on establishing a link between patient conditions and resource utilization (and wherever possible, outcome of care). The most significant contribution toward this end has been the Diagnosis—Related Group (DRG) classification system. DRGs classify inpatients according to mutually exclusive and exhaustive disease groups that make sense medically and are homogeneous with respect to the use of resources. That is, inpatients are differentiated in accordance with the level of resources utilized for their care, and at the same time in accordance with diagnostic categories. The DRG patient classification system permits hospitals to analyze their cases with a view to better understanding costs and improving quality of care. In addition, it can be used to determine hospital remuneration, either on a case—by—case basis (that is, determining a prospective reimbursement rate for each DRG, based on the DRG's average cost), or by setting an overall prospective hospital budget. Remuneration mechanisms along these lines can be helpful in promoting a more efficient use of resources. It is expected that DRGs will be increasingly used in Europe as a basis for negotiating contracts between hospitals and buyers of their services, for evaluating hospital performance, and for making comparisons across hospitals in costs and quality.*

−service specification based on health needs assessment
−volume of services
−price of services
−quality of care
−terms of care, such as waiting times and quality of hotel services in hospitals
−monitoring and evaluation procedures
−remuneration of individual providers (third party payers and physicians negotiate on levels of compensation for physicians).

Comprehensiveness of contracting

This relates to the scope of relationships regulated by of contracting. The usual case is that the purchaser contracts with the individual provider. Correspondingly the provisions of the contract specify the commitments of the individual provider irrespective of the commitments of other providers. For example the contract with a hospital specifies provision of certain number of cases for the certain amount of funding. The bigger is the number of referrals to hospitals by GPs, the higher is the income of hospitals.

The alternative to this type of individual contract is the comprehensive contract between the purchaser and the group of providers integrated in the vertical closed panel (hospitals, polyclinics, free−standing physicians, diagnostic centers, day care centers, etc.).The group is funded on capitation basis for provision of a defined set of medical benefits. The integrated approach to contracting is aimed at building up more close interactions of integrated providers in the search of more cost−effective and outcomes oriented strategies of health care provision.This strategy has brought to life the concept of managed care, which has been manifested in HMO−type settings. The major ideas of this concept have influenced NHS reform in Britain and currently are carefully considered in many Eastern European countries.

Comprehensive contracting implies two sets of contracts: i) between final purchasers and the integrated group of providers, ii) between providers within the group. For example, in the current experiment with HMO under ZdravReform Program for Russia in Kemerovo region 10 contracts are signed within the integrated system (primary care providers−specialists, polyclinics−pharmacies,etc). All units of the integrated system are subject to risk and incentives arrangements designed to have them bound by the common interest for the selection of the most effective strategies. The set of contractual provisions goes beyond volume, cost and quality characteristics, and includes risk arrangements, targets of decreasing hospital utilization, specialists and hospital admissions referrals authorization, quality management mechanisms, requirements to collection of data on outcomes and patient satisfaction.

To achieve the objectives of contracting, purchasers need to have more strong instruments of influence on providers' planning than currently exist in traditional pattern of relationships in Bismarck model. This implies closer links between purchaser and provider, including setting up joint management structures, represented by both sides. Purchasers must collaborate with providers in health care management, rather than act as indifferent translators of funds to fragmented medical facilities.

2. The implementation of contracting under current health sector reforms

2.1. The outline of contractual developments

The actual or potential practices in contracting in the countries of the European Region differ widely in accordance with the model of financing and organization of the health care system in each country.

The countries of the Region are divided into four groups for the purposes of describing the key trends: countries following the Beveridge model, countries following the Bismarck model, southern European countries with mixed model, and the CCEE/NIS. The rationale for forming the special group for the former countries is that their health systems are undergoing great restructuring with few or no clear−cut characteristics of Beveridge or Bismarck models. The emerging health systems very often do not fall into traditional typology of the systems. This is a transitional type of the systems.

The Beveridge model[3]

Health care systems adhering to this model are predominantly tax−financed, and are highly organized in the form of a national health service providing comprehensive services and coverage. The national health service traditionally has practiced comprehensive, formalized planning, programming, and budgeting. Contracting has traditionally played no role in the relationship between third party payers, which in this instance are government units, and providers (physicians, hospitals, or other provider institutions, which are for most part public), as both financing and delivery have been subsumed under the same organizational structure.

Health care reforms introducing contracting in this group of countries attempt to break the "command and control" elements of this model. Contracting entails the introduction of a split between third party payers and providers.

Three countries in this group have introduced, or are currently introducing contracting:

The UK. The contracting parties emerging following the third party payer−provider split include: On the payer side, (i) District Health Authorities (DHA), which previously were involved with the financing and management of hospital and community services; and (ii) fundholding general practitioners, consisting of large group practices (originally with over 9000 patients) who have exercised the option to receive the funds available for hospitals. The two groups of payers contract with quasi−public, self−governing hospital trusts,[4] with public hospitals managed by the NHS, private hospitals, and community services.

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[3] The Beveridge group includes the following countries: Denmark, Finland, Iceland, Norway, Sweden, and the United Kingdom.

[4] One of the elements of the UK reforms has been the opportunity offered to well managed National Health Service hospitals to become autonomous, self−governing trusts.

According to the above classification of contracts, DHAs are acting as commissioners rather than purchasers. However, the intention of health reform planners in the UK has been that eventually all public hospitals heretofore managed by the NHS will become autonomous hospital trusts. GP fundholders, on the other hand, act in the capacity of purchasers only.

Block contract was designed as the predominant type of contract at an early stage of the reform implementation. The idea was to avoid dramatic changes in the mix of services and patient flows in the absence of reliable information. But even block contracts differ from the original budget arrangements. They place more specific requirements to providers' performance, and they also provide for ceilings and floors for the level of the activity. Beyond the specified limitations, cost and volume arrangement came into operation.

Finland. Reforms of the state subsidy systems from the beginning of 1993 are leading to a "commissioner—provider" development. Finance and provision of health care in Finland have been the responsibility of municipalities. As part of reforms which altered the systems of state subsidies, municipalities were given greater freedom to organize the provision of services, and were permitted to take on a more active role vis—a—vis providers, though they still maintain responsibility for provision of health (and social) services. As a result of the reforms, hospital financing has changed so that their revenues now depend on volume and type of services requested by the municipalities.

Key objectives of these reforms include increasing municipal (local level) freedom and flexibility in services provision with a corresponding reduction in central government control, and go hand—in—hand with efforts to strengthen municipalities' position vis—a—vis hospital providers. It is unclear at this point in time whether these reforms will lead to a full—fledged purchaser—provider split as in the UK.

Sweden. Since 1983 health policy has been the responsibility of county councils (regional level government bodies). As part of efforts to explore new ways of financing and organizing health care, a number of counties at the end of the 1980s introduced the separation of financing from provision, along with purchasing and selling activities between counties and hospitals. Other elements of the reform are: i) increasing contracting relationships between local governments with private providers, ii) primary care providers in some counties are acting as purchasers of inpatient care ("Delarmodel"), iii) consumers gain new opportunities for the choice of outpatient care settings and maternity houses (van Otter and Saltman, 1992).

The Bismarck model[5]

Health care systems adhering to this model are predominantly insurance financed. Financing and delivery are institutionally separated, and contractual arrangements govern the relationships between third party payers, in this case

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[5] *The Bismarck group includes the following countries: Austria, Belgium, France, Germany, Luxembourg, Netherlands and Switzerland.*

insurance organizations, and providers. These systems are characterized by a lower degree of organization in that they are highly pluralistic. A pluralistic health system has the following characteristics (WHO, 1990):

− Decision−making power is not concentrated in the hands of one group or body but is dispersed among numerous groups, of which government units (at whatever level) are only one category of actors.
− The central government is in a relatively weak position, as much authority has been delegated to regional and/or local authorities, as well as to non−governmental organizations.
− National or sub−national policy (to the extent that it is developed at all) is thus determined not by government bodies alone, but rather through negotiations among a number of parties, typically including medical associations, insurance associations, associations of hospitals, nurses, or other health professionals, government bodies, and others.
− Ministries of Health (at the national, regional, or local levels) usually have limited responsibilities as direct providers of care (with the exception of tertiary hospitals and university teaching hospitals).
− A substantial proportion of partners in the decision−making process are private or quasi−public, including the various associations listed above, providers, as well as the non−profit insurance sector (the sickness funds).

Within this environment, contracting typically involves negotiating and bargaining over prices, remuneration levels, quality, and the global budget. Associations of sickness funds (the purchasers) contract with physicians' organizations for ambulatory care. In the case of hospital care, while associations of sickness funds negotiate the terms of contracts with hospital associations, the actual contracts are concluded between individual sickness funds and individual hospitals.

Health care reforms in this group of countries which directly involve contracting are quite limited, with the exception of the Netherlands and to a lesser extent Germany.

The Netherlands. Reform proposals of 1988 (the Dekker reforms) attempt to use contracting as a tool to increase the accountability of insurers (the purchasers) by shifting the balance of power between insurers and providers in favor of the former. The sickness fund relationship with providers (hospitals and physicians) is to be altered by abolishing the requirement that the sickness funds conclude contracts with all interested providers, and by granting freedom to the sickness funds to contract selectively with providers. In the new system, insurers will be able to exercise discretion over which providers they will contract with. Such voluntary contracting is expected to transform insurers from passive administrators/funders into more active purchasers/managers. While insurers have already been granted the freedom to contract selectively with physicians, this has yet to be implemented with respect to hospitals (Van de Ven, 1994).

The new scheme of contracting is designed to change the pattern of relationships between insurers and the public. The former now attempt to expand their market share by offering additional medical benefits, such as the option of annual check−up, the option of cross−border care in order to limit waiting time, and also extended set of medical services which go beyond the

basic package. This is a new development, as until recently in the Netherlands (and in other Bismarck model countries) the contract has nearly one hundred percent been determined by government regulation. The freedom of choice of insurers for the public was close to zero.

Another development is an increasing role of employer−based collective contracts. Employers negotiate contracts with health insurers for their employees. The contracts may include special medical benefits.

Germany. An effort to increase insurers' discretionary power over providers was initiated following the 1989 Health Care Reform Act. Sickness funds were given the freedom to cancel contracts with uneconomic hospitals, however the collective (as opposed to selective) nature of contracting remains. An additional relevant provision in the Act was that hospitals were obliged to publish price lists.

In the Bismarck group of countries, contracting between third party payers and providers focuses very much on levels of remuneration of providers. In Germany, for example, remuneration of physicians in the ambulatory sector is in accordance with the points system. Contracts concluded at the national level between federal sickness fund associations and federal physicians' associations establish a fee schedule, which includes about 2500 items of service, and relative points scale. These are infrequently revised. State−level sickness fund associations (the purchasers) negotiate and agree with state−level physicians' associations to pay a prospective lump sum which is distributed to physicians in accordance with the nationally negotiated fee schedule and the volume of services produced by each physician. Physicians are reimbursed on a fee−for−service basis using the fee schedule, the relative points value scale, and a monetary value per point. Since the total amount to be transferred to the physicians' association is fixed in the agreement, the fee per point is inversely proportional to the volume of services produced collectively by the physicians.[6]

Hospital remuneration is determined by contracting between hospital associations and sickness fund associations, and is based on an agreed average daily rate to be paid for each patient day.[7]

Contracts can additionally include agreements concerning the quality of services (in the hospital sector). However, the remuneration mechanisms discussed above do not allow room for purchasers contracting with providers to specify what services are to be provided (in both the hospital and ambulatory sectors), or on volume (in the ambulatory sector). In the ambulatory sector, the kinds of services provided are influenced by the inflexible, nation−wide relative points value scale, while volume is determined by physicians jointly with patients, both of whom are faced with incentives to maximize volume.

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[6] This results in a "prisoner's dilemma" in that while maximization of fees per point requires physicians to collectively reduce the services provided, each physician is motivated to increase the volume of services provided so as to maximize personal income.

[7] Volume is however controlled through prospective global budgeting.

Comparing contracting as currently practiced in the UK and in Germany, it becomes apparent that in Germany purchasers are more limited, particularly regarding the possibility of specifying the services to be required of providers.

Southern European countries

Greece, Italy, Portugal, Spain, Israel, and Turkey have mixed systems, combining elements of both the Bismarck and Beveridge models. The first four of these are in a process of transition from primarily insurance—based to primarily tax—based, and as such have either established or are in the process of establishing a national health service. These countries are not implementing contracting between third party payers (in this instance government or public bodies) and providers.[8] Israel is similarly in the process of moving from a mixed system to a predominantly tax financed one.

Turkey differs in that it is in the process of extending insurance coverage to previously uncovered segments of the population. Recent health care reform proposals include arrangements for purchaser—provider contracting. The proposals provide that insurance premiums (which are to be subsidized by tax revenues) collected from four insurance funds (three existing funds plus a new one to be established for the purpose of extending coverage), are to be transferred to provincial health directorates. The third party payers will therefore be the provincial health directorates, which will contract with selected hospital providers. The selected hospitals, for their part, are to be autonomously managed. These proposals have not yet been implemented.

The CCEE/NIS

Health care systems in these countries have historically been based on the Beverage model. A number of countries in this group are planning or have already begun implementing a change—over to an insurance—based system inspired by the Bismarck model, while many others have expressed an interest in the possibility of doing so at some future time. A few are attempting to implement contracting between third party payers and providers in the context of their newly established health insurance systems. Many of the issues surrounding the contractual arrangements between insurers and providers have yet to be worked out. Countries which are attempting to implement contracting through a purchaser—provider split include Bulgaria, the Czech Republic, Estonia, Hungary, Romania, and Russia. Further analyses is based on the Russian experience . Most of its contractual developments apply to other CCEE/NIS (see for example Ensor, 1993, von Bredow, 1995).

Russia. According to 1991 Health Insurance Legislation, mandatory health insurance (MHI) is introduced on a highly decentralized basis. Each of 88 regions builds up its own system of MHI. However, the major elements of the system are determined by the federal legislation country—wide. These are: 1) employers make income—related contributions to the Regional Fund of MHI for their employees;; 2) local authorities make contributions to this Fund for non—

[8] *In Spain, 1991 reform proposals included provisions for a purchaser—provider split which would have led to the development of contracting, however the recommendations were not accepted and no action has since been taken on them.*

working population and also finance directly a number of health programs and providers; 3) the Regional Fund allocates resources to competing insurers basing on a weighted capitation formula; 4) insurers (in some regions the branches of the Fund) pay to health providers (Sheiman,1994).

According to this pattern of financial flows at least 4 areas of contractual relationships arise between:

- employers and insurers;
- insurers and the MHI Regional Fund;
- local government and insurer (or the Fund);
- insurers and health providers;

In some regions regional or local health authorities contract directly with medical providers. But these contracts are relatively rare, because usually health authorities tend to allocate resources directly. Thus the major purchaser is the insurer or the branch of the Fund.

The types of contracts with providers are similar to those used in the UK. But the emphasis is made on different versions of cost per case contracts for hospitals and capitation contracts for polyclinics. Quality control and consumer complaints settlement are also included in the contracts. Providers are committed to perform according to the approved clinical standards and are subject to monitoring by insurers. There are specific provisions on the financial sanctions for the violation of standards, and also on the procedure of quality control. The scope of decentralization of management for hospitals, according to the contract, is not less than for the British medical trusts.

In most of the regions, contracts provide for purchasers to be the major risk—bearers. They are committed to pay for each case of inpatient care and in some regions for each services of polyclinics (e.g. in Moscow). To make it possible, risk arrangements between the Fund and insurers are contracted: each party is withholding some reserves to pay for unpredicted expenditures. But there is some evidence of growing interest in risk arrangement between insurers and providers. For examples, in Kemerovo region polyclinics are close to become fundholders for all types of outpatient care and specified portion of inpatient care, and thereby share risks with the insurers as final purchasers.

The regional MHI scheme is regulated by the collective contract (agreement) between regional government, the Fund and medical associations. It specifies the general rules of funding and management of MHI system, including the methods and rates of payment and the basic package of medical benefits. The major provisions of the collective agreement deal with the mechanisms of equalization of funding across insurers and, correspondingly, across subscribers. Thus the system is designed to introduce contractual relationships with providers while sticking to the principles of solidarity and equity.

2.2. The issues of contracting

In the course of the contracting implementation health systems have confronted many issues. Some of them are universal, others are specific to the contracting model selected by the country. Following are the exhibits representing the Beverage, the Bismarck and transitional models of health care.

The UK. The move to the more sophisticated cost and volume and cost per case contracting models is limited by the lack of information for the effective purchasing policy. The minimum information requirements for effective contracting cover patients flow data, cost and utilization information across specialties or diagnostic groups, demographic and risk group information. Large investments are needed in information systems, including in the capacity to process bills. It is also important to secure the dissemination of information to facilitate the rational choice of providers. In addition, a traditional resistance of health authorities and medical profession to collection and dissemination of health information, and also a tendency to manipulate the available information, must be overcome.

Related to this, is the issue of the rising transaction costs, that is the costs associated with continuing interactions of purchasers and providers (assessment of needs, analyses of the performance, negotiating, monitoring, etc.). An increase in quality and efficiency must justify these additional costs. Opponents to contractual model ardently appeal to these costs in all countries. Against this view, supporters of contracting point to the efficiency gains that have already been achieved or expected through new incentives and commitments of providers.

To cope with the issue of transaction costs, it is suggested by many scholars and health leaders to encourage purchasers and providers to enter into long−term contractual relationships rather than to view their task as one of making spot market deals. This would help avoid excessive transaction costs (Robinson and Le Grand, 1995).

To reconcile additional costs with new incentives of providers, it is commonly suggested to encourage competition of providers. The idea is to ensure "external check" on the tendency to form closed panels of providers with no or little selective contracting. It is assumed that the market forces will make providers be more responsive to competitive tendering. The absence or the lack of such checks has led to the proposals for an internal market in the first place (Enthhoven, 1985). As it discussed in section 3, the relevance of the problem is dependent on the factors which form the environment of contractual transactions.

Another issue of the emerging contracting model in the UK is the disintegration of purchasing policy. It is important to reconcile the responsibilities of DHAs and GPs as fund−holders. Former base their decisions on population health needs, latter−on individual patients' needs. To cope with the second issue, coordination of purchasing policy of different payers is needed. In Britain recent attempts to resolve the dilemma of dual responsibility for purchasing have sought to use administrative guidelines in order to integrate fundholders' purchasing plans more closely with those of DHA. (Robinson and Le Grand, 1995; Ham and Shapiro, 1995).

Russia. In addition to the above mentioned constraints to the viable contracting inherent to all highly integrated systems, specific constraints are in place in the Russian health sector. The major one is a great underfunding of the system. Public funding must be adequate and predicted so that to meet the bills of

contracted providers. This is a precondition of contracting process. In transitional economies this condition is rarely met. Health expenditures in Russia amount to only 3—4 per cent of GNP (the exact figure is unknown due to peculiarities of financial data collection). In addition, state commitments to provide free care with practically no user charges are very high even by the standards of more developed countries with highly socialized health systems. Thus, political declarations run into conflict with contractual arrangements.

A transition from direct allocation of resources to contracting relationships with providers in most of these countries is not an easy process. The major reason for a slow pace of the reform is unclear specification of the roles and responsibilities of insurance funds and health authorities. Contrary to the classic Bismarck model, health authorities keep responsibilities as direct providers of a high portion of health care. They tend to keep control over the financial resources for mostly non—contractual allocation to the providers. For example, in Russia the regional Governments have a lot of discretion in the choice of the model of health insurance in their region, and tend to control health funding directly. In most of the regions the share of contracted health expenditures in 1995 varied from 20 to 30 per cent. In relative terms this is a good progress. However, contracting is still far from being a prevailing model of relationships between payers and providers.

Another constraint is a disintegration of funding policy. Contrary to the purchasing disintegration in Britain, in Russia the disintegration is aggravated by the fact that one payer — health insurers — act as purchasing agencies, while the other — health authorities and local governments — tend to allocate recourses directly. Thus providers are acting under completely different economic regimes: contractual — with insurers and non—contractual — with the health authorities and the local government. This limits the scope of the application of performance—related methods and, therefore, reduces the efficiency of contractual part of the provider performance. There is a growing concern over this integration. To cope with the issue, health authorities and territorial health insurance funds in many regions have started conceited actions to coordinate their purchasing policy.

One more constraint is the lack of managing skills to operate the contracting process. Contracts require skills which are not needed under direct public provision such as those of identification of cost—effective medical interventions, negotiation and monitoring providers' performance. Furthermore, contracting implies high degree of decentralization of resource allocation since bids are likely to involve locally based providers too numerous to be dealt with at a central level and better known to locally based purchasers. It means that such skills are to be gained at the middle or bottom level of the system where capacity may be particularly weak. To generalize this point, capacity building is the prerequisite of viable contracting.

The Netherlands. An interesting policy issue in the context of the move from collective to individual contracting is whether this trend will make collective contracting unnecessary. It is obvious that, the potential of contorting is actually realized when contracts are signed with individual providers rather than their representative organization, like physician or hospital associations. This enables

payers to select providers with the highest performance indicators. The major requirement is that collective arrangements do not close the opportunities for the selection of providers and competitive tendering. insurers must be free to contract selectively under the general rules specified by the collective contract.

However, there are good reasons to believe that collective contracting is still needed and will most likely to co−exist with individual contracting. Insurers, providers and the government as well will always feel a need to negotiate collective arrangements which constrain or even discipline the market of individual contracting. Collective contracts offer a general binding framework in which local negotiations between third−party payers and providers can further take place. So collective contracts do not necessarily contradict individual contracts and sometimes even work as a prerequisite for individual contracting.

Thus contracting in three countries with different health models faces common issues, of which the most important are: the lack of management information and the skills for the viable contracting, and also disintegration of purchasing policy, high transaction costs. In addition, each country faces the specific issues. An extensive search for the ways of solving the issues of contracting has started with unclear outcomes so far.

3. Contracting in competitive environment

Contracting in many European countries is now more explicitly connected with the concept of market competition in health care − both on purchasing and provision sides. Contracts are increasingly seen as a coordinating mechanism in market, that is competitive interactions.

The introduction of market principles in health care has been at the forefront of these. "Market principles" do not here refer to the extreme organizational structure of a highly competitive market,[9] but rather to the relatively new development in health care of a planned or internal market. This entails the intentional development of a new market by the exercise of state power. This is pursued for the purpose of achieving state policy objectives through selective and limited use of market instruments. It involves decentralization of the planning process, as well as "the partial replacement of bureaucratic administrative mechanisms with market−derived incentives" (Saltman, von Otter, 1992, p.17).

The UK was the first country in which contracting between third party payers and providers was introduced on a broad scale in the context of the competitive framework produced by planned or internal market. Since then, many issues regarding the introduction of market forces and competition in the NHS have been debated (for example, Maynard,1994, Paton,1992, Spurgeon,1994, Whynes, 1993). These issues have included: i) the feasibility of providers competition in the systems which have been built and actually performed for decades basing on the principles of command−and−control economy, ii) the evidence of emerging competition, iii) the ways to encourage competition, iv) possible merits or

[9] As has been extensively discussed in the literature (for example, von Otter, Saltman), the perfectly competitive market model is neither attainable nor desirable for health care.

drawbacks that market forces and competition may entail, as well as pre−conditions of efficient competition. These issues are discussed briefly in this section.

3.1. Institutional constraints to competition

There are many reasons to doubt whether the new competitive forces can be easily "switched on" in the systems with deeply−rooted traditions of central planning. Central and Eastern European countries can serve as examples of the institutional constraints to competition. To the lesser degree these constraints apply to Western European countries with integrated systems.

The systems have established a hierarchy of providers on geographical basis with a special emphasis on a clear specification of the role of each type of medical facilities. In Russia, for example, the hospital sector is regionalized and divided between general and specialized hospitals with relatively little overlapping of their roles (Rowland and Telukov, 1991). They differ in equipment, skills of personnel and the package of services. A loosed pattern of population in many regions along with a high percentage of rural population, low quality of communication and transportation makes a substantial number of hospitals local monopolies with a small potential of competition between them.

In addition, in many countries with the emerging contracting model there are: i) economic and regulatory barriers to the entry to the market of new providers − high start−up costs, regulation on the deployment of resources, such as new bed capacity, purchasing major equipment; ii) the lack of effective labor markets, including the number and pay of the staff ("planned labor market"); iii) rigid regulation of payment rates to most of providers. There is also some fragmented evidence of the economy of scale in specialized health care provision, which may make big specialized hospitals more cost−effective Thus dismantling some local monopolies may be inappropriate.

These constraints have limited the range and scope of competition both in Eastern and Western European societies. In CCEE/NIS they are aggravated by a command−and−control system, in particular by the urge to establish primarily big institutions which can be easily administrated by health bureaucracy. The degree of concentration of hospital care here is very high according to Western standards. For example, most of the open heart surgery in Russia is concentrated in one central teaching hospital, while regional hospitals are usually not equipped for performing these operations. Such a high degree of provision concentration can also be attributed to the great underfunding.

Another constraint to competition, unknown to Western countries, is the dominant position of big polyclinics in ambulatory care. They concentrate all primary and specialized outpatient care in the catchment area. All residents are registered with the local polyclinic and are assigned to a specific primary care physician who is a salaried employee of the polyclinic. This doesn't allow a consumer choice−the major prerequisite of market relations. Thus the institute of a big polyclinic with a rigid catchment area impedes forming competitive environment.

It is also worth noting that the original pre−reform situation has greatly influenced the substance of the reforms placing special emphasis on the selection of the locus of potential competition and quasi−market relations.

In primary care the range of competition in Western Europe has originally been substantial, particularly in Bismarck model with the prevailing fee−for−service method of payment. Same holds true for free−standing specialists. For example, in Germany a high degree of competition in the area of primary and specialist ambulatory care has existed in the absence of individual contracting. As it is shown by Plaff, there is a strong evidence of general practitioners and specialists competing for patients and sickness funds resources. But the same research gives no evidence of the competition in the hospital sector, except for private patients (Plaff, 1990).

Similar conclusions have been drawn from the comparative analyses of 12 member states of European Community in the late 80−s. (Caspane et al,1988). Following are its major conclusions:

- practically no price competition across insurance funds under mandatory health insurance
- no price competition of state−owned and voluntary non−profit hospitals
- moderate price competition of private hospitals
- no or weak price competition of public and private ambulatory care units
- moderate quality competition in inpatient and outpatient settings, with stronger evidence for the private sector
- strong limitations on establishing new physician practices and hospitals
- strong marketing and advertising in the private sector
- weak or moderate contracting out of services by private providers
- strong competition of drugs and medical equipment producers.

Thus the major locus of the search for competition is the public hospital sector with an emphasis on price competition. In CCEE/ NIS the scope of the market−oriented reforms also extends to the ambulatory care, drug and medical equipment industries. Most of the areas of competition that have existed in Western societies for decades, are to be developed in the countries with the transitional economies.

3.2. The evidence of the emerging competition.

We address the evidence of two countries which have recently developed contracting −the UK and Russia.

The UK. Following is a summary of the evidence of the growing competition in the course of the NHS reform:

Increasing competition of hospitals. GP fundholding scheme encourages competition of hospitals. Hospitals are increasingly competing for patients referrals by GPs as fundholders. The latter can pick those hospitals or the units of hospitals which can give their patients a better and more convenient service.

The balance of power between primary care providers and hospitals has changed substantially.

Irrespective of the scope of their relationships with GPs, hospitals tend to be more patients oriented. Given substantial autonomy under trust status, it is easier for them to be responsive to consumer needs. The requirement to be involved in competitive bidding makes hospitals look for the ways to meet population and individual patients needs.

Increasing cross—boundary flows of inpatient care. Within the first two years of the reform nearly 80 per cent of the total number of contracts have been placed by DHAs outside their districts, while nearly the same percentage of the total value of contracts have been placed within their districts. This can be interpreted as the evidence of keeping up with the local hospitals in terms of the bulk of major services, while relatively small—scale contracts for provision of specific types of care have increasingly become more selective with an emphasis on less costly options (Robinson and LeGrand, 1995). These are the first signs of restructuring patients flows.

Purchasing more cost—effective care. In London for example districts are increasingly contracting with local hospitals rather than more expensive central teaching hospitals. This has led some teaching hospitals to merge as a preliminary to closing beds. There is an increasing interest in economic appraisal of alternative options of health care.

High requirements to quality of services. There are signs of increasing quality competition, since GPs as fund—holders pose higher requirements of quality of inpatient care. They can pressure specialists about waiting times and waiting lists. GPs can insist that test results come back as quickly as possible and thereby avoid patients' worries about the diagnosis. Moreover, taking all responsibilities for patients' care, fundholders tend to keep more close contacts with the patients in the process and after hospital admission.

It is worth noting that the British version of fundholding scheme seems to avoid the adverse evidence of denials of referrals to specialists or hospital admissions even when they are appropriate. The major reason for that is that GPs are acting in a competitive environment and therefore can not run into risk of playing games with their patients. As B. Abel—Smith points out, "fundholders know that their patients are free to go elsewhere, if they do not like the arrangements they make for them or hear of another group of GPs who take on the hospitals more assertively"(Abel—Smith, 1995, p. 5).

The problems of increasing competitions are usually linked to some evidence of the emerging two—tier system: GP—fundholders tend to select healthy patients and offer them a relatively higher regime of treatment. This problem has to be resolved, first, by making capitation payments to GPs more risk adjusted, second, by increasing the range of the scheme to cover most of the population and the the number of services funded by GPs —fundholders (e.g. not only selective surgery but even medical treatments requiring referrals to specialists and and hospital admissions). This can help avoid discrimination of patients. It makes more sense to built on what has been done and to expand the

involvement of GPs in the scheme rather than to fight discrimination by abolishing the scheme.

These and some other positive evidence of the emerging competition in the NHS (see for example Smee, 1995) has not reduced the reservations on the possibility of creating the efficient internal market. Many experts indicate that the "soft" version of the reform does not overcome institutional constraints to competition, of which the most important in the UK are inflexibility of resource supply, limitations on providers entry and exit, the inflexibility of labor and capital markets, the lack of information for consumers.

These factors also make the outcomes of competition unclear in terms of efficiency and equity of care. As it is noted by A. Maynard, "no proper evaluation of the reforms has been carried out and it is impossible to determine whether competition in health care is efficient" (Maynard, 1993, p.202). Another interpretation of the same constraints is given by J. Le Grand in the recent paper: "Overall, even though quisi—markets in health care may not be the perfect system for allocating resources in the area, this may be the least worst" (Le Grand, 1995, p.3).

Russia. A transition to the health insurance model in the context of the market reforms in the economy has brought the first elements of competition in different sectors of health care. The most radical changes have taken place in pharmacies, drugs and medical equipment industries. Lifting price control, along with privatization policy and liberalization of foreign trade, have created the market for these goods and services with vigorous competition of producers and dealers.

In primary care the new legislation allows free choice of polyclinics and physicians in the polyclinic, which is designed to encourage competition. In practice, in most of the regions, very little is done to ensure consumer choice. Physicians in polyclinics have no strong incentives to increase the list of patients; rigid catchment areas still exist for each polyclinic and physician within the policlinic; open enrollment procedures are not implemented; consumers are lacking information for the rational choice; there is no alternative to big state—owned polyclinics. Thus consumer choice and competition in primary care is so far the mere declaration. Fragmented experiments in a few regions with decentralization of management in polyclinics seem to be promising for encouraging competition, but their scope is negligible.

It is worth mentioning that contrary to the British version of fundholding scheme, a similar scheme has been designed primarily with the aim of encouraging polyclinics to take the major burden of health care rather than to encourage competition of hospitals. In the specific situation of Russia this is also the way to strengthen primary care provision and to reduce the excessive bed capacity and number of physicians. The experiments in a few regions have managed to achieve this goal. But the lack of competition of primary care providers did not allow to avoid the adverse evidence of denials of referrals to hospitals when they are appropriate (Sheiman,1995).

In the hospital sector the purchasing policy has not been designed to encourage competition as well. Contrary to the British reform, regulation in Russia does not

give much scope for price competition. Hospitals are paid according to the authorized rates.

One of the major constraints to competitive tendering is that insurers as purchasers of care are contracting with employers rather than individuals, therefore they do not compete for subscribers through traditional market mechanisms. The prevailing model is that insurers negotiate with the Fund their market shares (the list of catchment areas), and base their purchasing decisions on the local health resources rather than the actual patients choice. In addition, great underfunding does not leave much space for increasing the package of medical benefits beyond the basic package.

The only area of the growing and substantial competition is the private sector. Private patients are looking for the access to the best equipped medical facilities. Hospitals, polyclinics and also private health insurance companies are competing for patients and subscribers. Voluntary health insurance plans are offering additional services in the best medical facilities.

In spite of the lack of competition, there are obvious signs of revitalization of the Russian health sector in terms of increasing efficiency. The growing tendency is to apply performance—related methods of payment to hospitals. Currently, more than 60 per cent of hospitals are paid by insurers on cost per case method (the regional versions of DRG method). This has created strong incentives for increasing the occupancy of hospitals, reducing the average length of stay. Polyclinics are increasingly paid by capitation method (25,3 per cent of polyclinics apply this method) and fee—for—service method (33,6 per cent)(Federal Fund, 1995). The impact of performance—related methods of payment on the allocative efficiency and the structure of health care is not clear. But the internal efficiency of both hospitals and polyclinics has definitely been positively affected. Now they are interested in increasing the workload. The shift from input to output—based indicators has started the process of reducing unnecessary bed capacity, deployment of day care centers and other alternatives to the costly inpatient care.

Quality control has become tougher. For example, in Kemerovo region around 8 per cent of inpatient cases are currently subject to quality control by insurers with penalties for poor quality (Quality assurance, 1995, p. 47). Insurers are increasingly acting as champions of patients' interests. They set up special units which are responsible with settlement of patients' claims.

This positive evidence can hardly be attributed to the growing competition. Rather, this is the result of the move from input—based direct allocation of resources to contracting mechanisms which are based on performance—related methods of payment, new information requirements, decentralization of management, monitoring of performance.

The Russian case can be an illustration of the point that contracting can give positive results in both competitive and non—competitive environment. In the former case the increase in efficiency and resource allocation can be achieved through competitive mechanisms. In the latter case — through the new instruments of planning, management and payment of providers. The pressure of the market is needed to realize the potential of contracting, but even in the

absence of this pressure a lot can be gained in terms of efficiency and quality. This can serve as a starting point for collecting the information needed for more selective and more competitive contracting. At further stages of reform implementation it will be easier to ensure " the exit" of unnecessary capacity and more profound changes in the structure of health care towards more cost−effective medical interventions.

In summary, the scope and range of competition differs across countries and across sectors of health systems within each country. There are more elements of competition in outpatient care than in inpatient care sector. Hospitals are increasingly exposed to new forces, driven by health reforms. However, the responsiveness of hospitals to these forces and outcomes are can hardly be now the subject of strong generalization. The feasibility of competition and its positive impact on efficiency and quality of care are largely dependent on the design of the reforms and also on the economic and political context of their implementation.

The role of purchasers is of vital importance for making competition feasible and efficient.

3.3. The role of purchasers in encouraging providers competition.

Given institutional constraints to competition, it is unrealistic to expect that a transition from integrated to contractual model of health care can start in a competitive environment. Two general observations can be made regarding the role of purchasers. First. They should start looking for the potential zones of competition which are available even in highly hierarchical systems. Moreover, competitive environment should be designed and encouraged as a component of public health policy. Following are the examples of possible actions of purchasers:

- To start restructuring big polyclinics into free−standing solo and group practices and contract with them directly for provision of outpatient care. This has been implemented in most of Eastern Germany lands with obvious outcome of creating competitive environment in ambulatory care provision (Jacobs, 1994). The process of restructuring has started in Chech Republic, Hungary, Romania (WHO, 1993). There is anecdotal evidence of establishing independent GPs in Russia, Kazakhstan, Estonia.
- To make primary care providers fundholders for specialist outpatient care (referrals to specialists, lab tests, etc.) and for a small portion of inpatient care. Primary care providers can selectively contract with specialists and hospitals basing on the evaluation of the cost and quality of care they provide.
- To encourage the start−up of day care centers, outpatient surgery and other alternatives to the expensive hospital care.
- To encourage development of new private providers, particularly in ambulatory care sector, and to integrate them into the system of public funding on competitive basis.
- To evaluate cost−effectiveness and encourage development of the most promising medical technologies which might successfully compete with the existing medical interventions.

- To increase contracting with small district hospitals for relatively simple cases and deny central hospitals contracts for inappropriate admissions. The mere reallocation of patients flow may promote competition between different types of hospitals. Part of this process is establishing criteria and guidelines for selecting the point of care for different cases in the range of hospitals hierarchy. In addition, the rates of payment for inpatient care must reflect the actual cost of care in different types of hospitals so that to make prohibitive purchasing care for relatively simple cases from the elite hospitals.

Another approach to encouraging competition is the requirement to use the mechanism of competitive tendering, particularly in big urban areas where there is a substantial scope for selecting the hospitals with lower costs and higher quality. This implies: i) open choice of provider's tenders to fund them for real value of their services; ii) ensuring careful monitoring and evaluating providers' performance. The potential of competition is largely depended on the way the contracting process is managed.

3.4. Approaches to competitive contracting

To make contracting competitive certain rules and procedures must be developed and implemented. They are to be made a part of the reforming process, which was the case in NHS in Britain at the early stage of its reform (Contracts for Health Services, 1990). Similar approaches are developed in other countries which are building planned or regulated markets. The specific algorithm of contracting is either developed or implemented.

To make contracting competitive, certain steps are to be made.

Step 1. Purchasers make an assessment of health needs.

Step 2. Priorities on resource allocation are set basing on needs assessment. Targets for resource utilization are developed and made available to providers. This includes the rate of referrals to specialists, rate of admissions, number of hospital days per 1000 residents etc. The specialties and case−mix priorities, and the most cost−effective medical interventions are also determined to ensure improvement of health care provision structure. Basing on this assessment and target indicators, providers plan their work. The key parameters of planning is deployment or closing bed capacity, procurement, training of the personnel.

Step 3. Purchasers set their requirements as to the volume and quality of care. They issue a statement describing both the type of service, they are interested in buying, and the issues of quality it would wish any prospective provider to address in a contract. The greater commitments of the provider regarding quality dimensions, the higher chances for its winning the contract. Actually, this is probing into the potential of competing providers. For example, the requirements for delivery cases stipulate for bidders to provide a flexible range of options for antenatal care (including a certain number of home visits); ensure first contact of women within a specified period of pregnancy; decrease the probability of delivery complications; provide parentcraft sessions, etc. It is particularly important that this originating statement is as open as possible in order to attract more providers for negotiating process.

The actual mode of service specification may differ. In Russia an emphasis is made on clinical standards which specify the minimum requirements of services and procedures for each diagnosis. So the range of options as to the set of quality characteristics is relatively small. In Britain statement is not explicit on how the services should be provided. Providers are not limited in their response to requirements (Contracts for Health Services, 1990).

Stage 4. Providers evaluate their capacity to meet the specified requirements and apply for the contract. The application specifies the expected volume of cases, their cost (average for specialty or across the case—mix) and quality characteristics. The important requirement is to make the application parameters open to all potential applicants. This is designed to encourage competition of applicants as to the cost and quality.

Stage 5. The application is analyzed by the purchaser and negotiation starts with applicants. The final agreement is to be reached on each parameter of the application. The optimum balance among volume, cost and quality is the objective of the purchaser.

Stages 6 and 7. Monitoring and evaluation of provider's performance are stipulated by the regulation and the contract. First of all, this is the requirement to provide all necessary information regarding the performance of the medical facility. This may also be required that the purchaser has a full access to clinical information.

To ensure the smooth process of competitive contracting at least following preconditions are to be met:

- To improve the volume and quality of data about costs and cost effectiveness.. The effective purchasing policy must be based on the reliable and commonly agreed data on costs and expected cost effectiveness of alternative interventions. To achieve this, clinical trials and economic evaluations are needed.

- To tighten requirements on quality and outcomes data across medical facilities so that to avoid trade—off between quantity and quality of care. The emphasis is to be placed on the outcomes rather the process indicators.

- Positive incentives for providers must be combined with negative incentives, i.e. loss—making facilities can be closed or, at least, have low compensation of the staff than more efficient facilities. To achieve this. the fixed rates of collectively negotiated pay should be regarded only as the minimum rates. The substantial and growing share of compensation should be performance—related.

- Funding of different purchasers should be equalized on the basis of risk—adjusted capitation formula so that to facility cross—boundary purchasing (Maynard, 1994).

Thus competitive bidding requires careful design of contractual procedure and also the regulation of some characteristics of the contract. This mechanism together with identification and encouragement of potential areas of competition may be regarded as the potential ways to overcome institutional constraints to competition.

4. Conclusions and recommendations

The growing interest in contracting can be attributed to the disappointment with traditional mechanisms of command and control pattern of resource allocation. It is the thesis of this paper that contracting can be implemented in both competitive and non−competitive environments. In both cases contracting can be regarded as planning and management tool.

Contracting thus represents a new and different way to do many of the things that the management of health care and planning have traditionally been preoccupied with, and a way that can simultaneously redress certain difficulties of traditional planning methods, while achieving a number of public health objectives.

With some degree of convention it is possible to identify four generic trends in contracting across countries with different health models.

- From block contracts to cost and volume and cost per case contracts
- From collective to individual contracting
- From old−style contracting with the specified set of providers to the market oriented selective contracting
- From contracts with a few provisions (primarily on volume and quality) to the more sophisticated contracts with a number of provisions on cost containment, utilization management, quality assurance, risk sharing arrangements, etc.

The relevance of these trends differ across countries. But to a different degree they are either in place or expected in al health systems undergoing the major reforms.

The actual implementation of the contractual process does not necessarily match theoretical expectations. Contracting confronts many obstacles and issues, of which the most important are the lack of information, managing skills of health purchasers and providers, high transaction costs, and in CCEE/NIS − inadequacy of public funding.

Another observation from the analyses is that the first attempts to introduce contracting in countries, which have long been totally deprived of economic mechanisms of resource allocations and providers' autonomy, can give good results without competitive bidding. The minimum set of pre−conditions for this includes:
−performance−related methods of payment, which match health objectives and priorities, are to be designed and implemented;
−more power is delegated to providers;
−management information systems are developed.

In other words, in some countries contracting can increase efficiency and quality of care through better planning, management and more appropriate methods of

payment, in others – through more competitive mechanisms which make better planning and management the way to achieve market objectives of providers.

The analyses of contracting gives grounds to the specific recommendations for health policy makers.

1. To make contracting the prevailing model of health finance, planning and management.

A share of revenue directly allocated by health authorities should be limited to the clearly specified items of expenditures or services. What should be avoided is non-contractual allocation of funding for major part of providers activity. This reduces the potential of performance-related contracts: providers lose motivation for higher performance. This is the uniformed recommendation for all health models.

2. To design contracting models and procedures in the context of health policy objectives.

Each country has its priorities and objectives of health policy. For example, if the priority is cost containment, contracting should be designed in the context of the current efforts to put the limits on providers' budgets, cost sharing, etc. Contracts based on the retrospective payments (cost per case or fee-for-service) should give rise to the contracts which are more focused on prepayment (e.g. case-mix adjusted global budgets) and also on comprehensive contracts with integrated groups of providers under capitation schemes. If the priority is to encourage providers to use idle capacity (the case of CCEE/NIS), the emphasis should be placed on the retrospective cost-per-case contracts. In all health models contracts must be designed to encourage primary care provision as the major objectives. Community-based and environmental services should also be included in contracting arrangements.

3. To make a shift from direct health provision and resource allocation incremental.

The viable contracting must meet certain requirements of which the most important are operational autonomy of providers, adequacy and stability of funding, the managing skills and other forms of capacity building. Some of these requirements are not met in transition economies and also in Western countries with highly integrated systems. This may imply setting reasonable targets of the share of contractual health expenditures (through contracts). To make contracting politically acceptable, interest groups should be identified and involved in contracts design and implementation. Refined regulation on monitoring and evaluation of contracts is also needed to be developed and enacted.

4. To make the local choice and providers' competition a component of health policy strategy with an emphasis on the new role of health purchasers (health authorities and insurers) in encouraging competition

The actual implementation of this strategy differs across countries. The emphasis is to be placed on the role of health purchasers in collecting data on costs,

quality and cost effectiveness of care for selective contracting and also on facilitating the local choice by dismantling local monopolies wherever it is possible. In addition, it is important for purchasers to ensure an open choice of providers' tenders to fund them for the real value of their services, and also careful monitoring and evaluating providers' performance.

5. To specify explicitly the roles and responsibilities of different agencies involved in funding health care.

This is particularly desirable in the countries with transitional health systems, where traditional role of health authorities as direct providers remains. In this context, it is important to coordinate non−contractual resource allocation by health authorities with contractual arrangements of new health care purchasers.

6. To avoid disintegration of purchasing policy.

In countries with multi−payer systems it is important to coordinate the responsibilities of different payers (e.g. health authorities and sickness funds). This can be done by the long−term contractual relationships or conceited actions of different payers. Regulatory guidelines might be needed to integrate purchasing plans.

7. To build capacity for the viable contracting.

This implies development of managing skills for all elements of contracting, particularly at low and middle level of managers.

8. To expand the scope for price competition of providers.

The emphasis in purchasing policy is to be placed on the competitive selection of the providers with the highest cost effectiveness. This implies a move from the regulated rates of payment to providers to the negotiated rates. Providers are to bid for contracts basing on the indicators of costs, volume and quality.

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